



Published on AIDSFree (<https://aidsfree.usaid.gov>)

[Home](#) > [Resources](#) > [AIDSFree Guidance Database](#) > [TB Guidance Database](#) >

Kenya

The following provides a summary of specific guidelines from the country's national TB guidance strategy. Use the jump links in yellow to access details on case definitions, diagnostic methods, standard protocols, and DOTS recommendations. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be found below the jump links for download.

Patient Population [Download summary page as PDF](#) [E-mail this page](#)

Suggest Updates

- [Adults](#)
- [Children](#)
- [Pregnant and Breastfeeding Women](#)

Adults

Year Issued:

2009

TB Screening Frequency for PLHIV:

All persons found to be HIV positive at HIV testing sites including VCT centers, STI clinics, PMTCT sites etc should be screened for TB and referred to the nearest TB diagnostic centres. This is more critical in clients who have a cough, fever, weight loss, or have lymph node enlargement. All HIV infected individuals should be screened for TB at initial enrollment into HIV care and at each clinical/ follow-up appointment.

Screening Recommendations during TB Treatment:

Patients on TB treatment should be monitored for:

- Bacteriologic response - follow-up sputum smears for all smear positive patients:
 - Patient treatment on EH - follow up sputum smears at 2, 5 and 8 months
 - Patient treatment on RH - follow up sputum smears at 2, 5 and 6 months
 - Patient treatment on retreatment - follow up sputum smears at 3, 5 and 8 months.

Case definition:

Pulmonary tuberculosis, sputum smear positive (PTB+)- Two or more initial sputum smear examinations positive for acid fast bacilli (AFB), or - One sputum smear examination positive for AFB plus radiographic abnormalities consistent with active pulmonary tuberculosis as determined by a clinician, or - One sputum smear positive for AFB plus sputum culture positive for mycobacteria tuberculosis.

Diagnostic methods:

Sputum culture examination

Chest X-ray

Standard TB Treatment Protocols:

The treatment regimen for new adult category 1 and 3 TB patients is:

2RHZE/6EH or 2RHZE/4RH which is offered through WEEKLY drug collection during the intensive phase and TWO weekly (RH) or monthly (EH) during the continuation phase. Since most defaults happen in the first two months of treatment, weekly drug collection during the intensive phase is particularly important to identify potential defaulters.

The treatment regimen for Category 2 (retreatment TB patients) is:

2SRHZE/1RHZE/5RHE The intensive phase is therefore 3 months with daily injections of Streptomycin and swallowing of RHZE in the first two months and weekly drug collections in the third month, followed by 5 months of continuation phase with two weekly drug collections. DOT throughout has to be guaranteed.

DOTS Recommendations:

The Division of Leprosy, Tuberculosis and Lung Disease (DLTLD), in line with international trends, has launched several new approaches to increase access to DOTS and truly expand population DOTS coverage. These approaches include community based DOTS (CB-DOTS), Public-Private Mix for DOTS (PPMDOTS), collaboration between TB and HIV control programs and the development of an elaborate advocacy, communication and social mobilization strategy aimed at influencing communities to seek care early when TB symptoms occur and to remain on treatment until this is completed when treatment is initiated.

The delivery of DOTS services is integrated into the general health services provided at health care delivery points.

Tuberculosis control strategies in Kenya – the Stop TB Strategy. Pursuing quality DOTS expansion and enhancement through:

- Political commitment with increased and sustained financing
- Case detection through quality assured bacteriology
- Standardised treatment, with supervision and patient support
- Effective drug supply and management system
- Monitoring & evaluation system, and impact measurement.

Children

Year Issued:

2009

Screening Recommendations during TB Treatment:

Ideally, each child should be clinically assessed at 2 weeks after treatment initiation, at the end of intensive phase, and every month until treatment completion. The assessment should include, at a minimum, a symptom assessment, an assessment of adherence, inquiry about any adverse events, and weight measurement. Medication dosages should be adjusted to account for any weight gain. Adherence should be assessed by reviewing the treatment card. A follow-up sputum smear for microscopy at 2 months should be obtained for any child who was smear-positive at diagnosis. Follow-up chest radiographs are not routinely required in children, particularly as many children will have a slow radiological response to treatment. A child who is not responding to TB treatment should be referred for further assessment and management.

Case definition:

TB should be suspected in any child who presents with the following:

- Chronic unremitting cough for more than two weeks.
- Physical signs suggestive of TB (e.g. fever of greater than 38°C for two or more weeks, failure to gain weight or weight loss (growth faltering)
- A positive tuberculin skin test
- Suggestive chest X-ray

Presence of 3 or more of the above strongly suggests TB.

Diagnostic methods:

The key elements to a successful diagnosis of PTB in children include:

- Careful history taking (including history of TB contact and symptoms consistent with TB)
- Clinical examination (especially growth monitoring))
- Smear microscopy
- Tuberculin skin testing (TST)
- Chest radiography
- HIV testing

Standard TB Treatment Protocols:

The recommended regimen for all forms of TB in children in Kenya is 2RHZ/4RH.

In childhood TB cases where anti-tuberculosis treatment fails or a relapse occurs, every effort should be made to find the most likely cause for the failure of treatment or relapse. Failure of treatment in confirmed TB is more likely to be due to drug resistant TB. Therefore all children who fail first line anti-TB treatment should as far as feasible have specimens submitted to a laboratory for mycobacterial culture and Drug Susceptibility Testing (DST). While results are awaited the child should be placed on the 2SRHZ (E)/1RHZ (E)/5RH (E) regimen.

DOTS Recommendations:

The management of all children with TB should be in line with the DOTS strategy, including daily directly-observed treatment.

Pregnant and Breastfeeding Women

Year Issued:

2009

Standard TB Treatment Protocols:

In general, pregnancy should be avoided during anti-TB treatment. However when it occurs, termination of pregnancy should not be recommended. Like most drugs, anti-TB drugs have not been specifically studied in pregnancy. There is always some risk of teratogenicity with any drugs especially when the drug is given in the first trimester. There have been no significant reports that anti-TB drugs pose a greater than usual risk of teratogenicity and therefore all pregnant women with active TB should be treated with a full complement of anti-TB drugs. It is useful to give Pyridoxine with Isoniazid to avoid the small risk of damaging the infant's nervous system. Streptomycin should not be used in pregnancy because it may cause deafness in the infant. When treating drug resistant TB the aminoglycosides (Kanamycin, Amikacin and Capreomycin) and the thioamides (Ethionamide and Prothionamide) should not be used in pregnancy because of associated ototoxicity.

Source URL: <https://aidsfree.usaid.gov/resources/guidance-data/tb/kenya>